KEVIN V. RYAN (CSBN 118321)
United States Attorney

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. DILBAGH S. CHATTHA, Defendant.	No. CR-04-40003-DLJ VIOLATIONS: 18 U.S.C. § 1347 – Health Care Fraud; and 18 U.S.C. § 1341 – Mail Fraud OAKLAND VENUE

SUPERSEDING INDICTMENT

The Grand Jury charges:

INTRODUCTION

At all times material to this Indictment:

A. THE DEFENDANT

1. CHATTHA was a medical physician licensed to practice medicine in the State of California. CHATTHA maintained a medical office at 1860 Mowry Avenue, Suite 303, Deccan Pacific Plaza, Fremont, California.

B. THE HEALTH CARE BENEFIT PROGRAMS

2. CHATTHA participated as a provider of medical benefits, items, and services to patients covered by various health care benefit programs, including the Federal Employees Compensation Act (FECA), 5 U.S.C. § 8101 et seq., the Medicare Part B Program under the Social Security Act, 42 U.S.C. §§ 301 et seq. ("Medicare Part B Program"), and the California Workers' Compensation System established under California Labor Code Sections 4603.5 and 5307.1. These three programs will be referred to collectively as the "health care benefit programs".

3. The FECA provides for the payment of disability compensation benefits for federal civilian employees of the United States government who incur on-the-job injuries or employment-related diseases or illnesses. The FECA also provides for the payment of all related medical costs. The United States Department of Labor, Office of Workers' Compensation Programs ("DOL-OWCP") administers the FECA.

4. The Medicare Part B Program provides for supplementary medical insurance benefits for individuals aged 65 years and older who are entitled to Social Security benefits. Medicare Part B reimburses a percentage of the reasonable charge of most medically necessary services performed, ordered or appropriately supervised by a licensed medical practitioner. The Medicare Part B Program is administered by the United States Department of Health and Human Services ("HHS").

5. The California Workers' Compensation Program authorizes payments for medical services provided to employees working in California who incur on-the-job injuries or employment-related diseases or illnesses. Payments are made according to an Official Medical Fee Schedule ("OMFS") that governs all covered medical services provided, referred, or prescribed by physicians (as defined by California Labor Code Section 3209.3). The California Workers' Compensation Program is administered by the California Division of Workers' Compensation.

6. For purposes of this Superseding Indictment, the patients covered by the health care benefit programs are called "claimants." The physicians who see and treat program

claimants are called "providers." Each of the health care benefit programs described above, fits the definition of a health care benefit program, as defined by Title 18, United States Code, Section 24(b) which defines "health care benefit program" as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract."

C. THE CLAIM FOR REIMBURSEMENT PROCESS

7. The DOL-OWCP, Medicare Part B Program, and the California Workers' Compensation Program pay providers based on claims for reimbursement filed by the provider following his or her provision of medical benefits, items, or services to a claimant. Typically, providers submit a form called a HCFA 1500 to the DOL-OWCP, Medicare Part B Program, or the California Workers' Compensation Program to document their claims for reimbursement under each of the health care benefit programs. CHATTHA used HCFA 1500 forms.

8. CHATTHA submitted, or caused his staff to submit, his procedure notes to each of the health care benefit programs as backup or support for his claims for reimbursement. CHATTHA dictated most of his procedure notes simultaneous to his visits with patients. CHATTHA directed his billing staff to prepare the claims for reimbursement and submit them to the pertinent health care benefit program for payment.

D. BILLING CODES AND PROCEDURES

9. Providers must use codes established by the American Medical Association (AMA) to identify each procedure and service for which the provider seeks reimbursement. The AMA calls the billing codes the "Physician's Current Procedural Terminology" or "billing codes," (hereafter "CPT codes"). Providers must accurately list the CPT code that most completely identifies the procedures performed and services they

perform or provide. Pursuant to the language in the HCFA 1500 form, providers certify the accuracy of their claims for reimbursement at the time they submit them for payment. Most often, the DOL-OWCP relies solely on the accuracy of the information providers put in the HCFA 1500 form when approving claims for reimbursement. Sometimes, however, the health care benefit program may ask a provider for their procedure notes or similar documentation before paying a claim.

10. CHATTHA was familiar with and used the CPT billing codes, and directed his staff to prepare HCFA 1500 forms using those codes. At issue here, are physician services known as office visits, special reports, and the administration of needle electromyography tests.

E. OFFICE VISITS

11. The CPT code addresses billing guidelines for physician services in a section entitled "Evaluation and Management (E/M) Services." The E/M section itself is divided into broad categories such as office visits, hospital visits, and consultations. These broad categories are then divided into subcategories. The E/M section on office visits sets forth billing guidelines according to a patient's status as "new or established."

12. The CPT Manual states that "a new patient is one who has not received any professional services from the physician within the past three years." The CPT Manual states that "an established patient is one who has received professional services from a physician within the past three years." The counts in this Indictment relate solely to established patients.

13. E/M classifications are material because physicians get paid depending on several factors relating to his or her performance or supervision of patient services. Because services provided by a physician vary based on the nature of the physician's work, the CPT Manual requires physicians to document specific information regarding their own or their staffs' encounters with patients. The CPT Manual details the level and nature of the documentation required of the physician to bill the different levels of office

visits.

14. The CPT Manual recognizes five levels of service depending upon an evaluation of the following seven factors: (1) medical history; (2) medical examination; (3) medical decision making; (4) counseling; (5) coordination of care; (6) nature of presenting problem; and (7) time. Factors (1) through (3) constitute key components in selecting the level of service. Factors (4) through (6) are considered contributory factors in the majority of office visits, although it is not required that these services be provided at each patient office visit. Factor (7), time, is not considered to be a key or controlling factor in selecting the level of service unless counseling and/or coordination of care constitutes more than 50% of the time spent by the physician/patient and/or family encounter.

15. The CPT Manual lists the following five billing codes for office visits:

Level One – 99211 is an office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal, and typically five minutes are spent performing or supervising these services.

Level Two – 99212 is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: a problem focused history; a problem focused examination ; and/or straightforward medical decision making. Usually, the presenting problems are self-limited or minor, and typically physicians spend ten minutes face-to-face with the patient and/or family.

Level Three – 99213 is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: an expanded problem focused history; an expanded problem focused examination; and/or medical decision making of low complexity. Usually, the presenting problems are of low to moderate severity, and typically physicians spend fifteen minutes face-to-face with the patient and/or family.

Level Four – 99214 is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: a detailed history; a detailed examination; and/or medical decision making of moderate complexity. Usually, the presenting problems are of moderate to high severity, and typically physicians spend twenty-five minutes face-to-face with the patient and/or family.

Level Five – 99215 is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: a comprehensive history; a comprehensive examination; and/or medical decision making of high complexity. Usually, the presenting problems are of moderate to high severity, and typically physicians spend forty minutes face-to-face with the patient and/or family.

16. Throughout the period covered by the Indictment, CHATTHA billed for Office Visits at Level Five under CPT code 99215 routinely.

F. SPECIAL REPORTS

17. The CPT code 99080 permits the submission of a "special report" for an unlisted service or one that is unusual, variable, or new. The purpose of the "special report" is to demonstrate the medical appropriateness of the service rendered. Pertinent information includes an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care. "Special reports" include more than the information conveyed in the usual medical communications or standard reporting form. Throughout the period covered by the Indictment, CHATTHA billed for Special Reports under CPT code 99080 routinely.

G. ELECTROMYOGRAPHY

18. CPT codes 95860-95870 permit the submission of claims for the administration of needle electromyography ("EMG") tests. The EMG is an electrodiagnostic study performed by a physician (generally neurologists or physiatrists) as part of an overall consultation which includes history-taking, appropriate physical examination, and the design, performance, and interpretation of electrodiagnostic studies. The consultations usually take a minimum of 30 minutes to perform and can take up to two hours or more in particularly complicated clinical situations. The needle EMG is performed to exclude, diagnose, describe, and follow diseases of the peripheral nervous system and muscle. Needle EMGs permit the recording and study of electrical activity of muscle using a needle electrode that is inserted into appropriate muscles, one at a time. The procedure is painful for the patient. The needle electrode allows the muscle's

electrical characteristics, at rest and during activity, to be interpreted by the physician. The interpretation includes analysis of oscilloscope tracings and characteristic sounds produced by electrical potentials. The final interpretation of the study is a combination by the physician of the patient's history, physical examination, and preceding portions and following portions of the study. The needle EMG studies are interpreted in real time.

H. THE SCHEME TO DEFRAUD

19. Beginning at least as early as January 1, 1999 and continuing through at least in or about March 31, 2004, in the Northern District of California and elsewhere, CHATTHA knowingly devised and intended to devise a scheme

> (1) to defraud the health care benefit program conducted under the FECA and administered by the DOL-OWCP, the Medicare Part B Program administered by the HHS, and the California Workers' Compensation System administered by the California Division of Workers' Compensation and
>
> (2) to obtain, by means of false and fraudulent pretenses, representations, and promises, money belonging to and under the care, custody, and control of these health care benefit programs.

20. CHATTHA accomplished this scheme by mailing or electronically transferring claims for reimbursement that included health care claim forms containing false and fraudulent information to health care benefit programs to obtain, and attempt to obtain, payment for the billed items. In this regard, CHATTHA:

a. Submitted claims containing billing codes in support of requests for payment for Level Five office visits under CPT code 99215, knowing that he had not performed services at the level set forth in the CPT Manual for CPT code 99215 and that he did not submit the documentation necessary to justify billing for a Level Five office visit under CPT code 99215;

b. Submitted claims containing billing codes in support of requests for payment for "Special Reports" under CPT code 99080, falsely asserting that he had performed an unlisted service or one that was unusual, variable, or new and met the other criteria set forth in the CPT Manual. In truth and in fact, however, as CHATTHA then well knew, the services he provided to his patients did not support his claim for reimbursement for a

"Special Report" and did not meet the criteria under CPT code 99080. Specifically, CHATTHA simply supplied his diagnostic notes in the form of a progress report and then submitted a claim for reimbursement for a "Special Report."

c. Submitted claims containing billing codes in support of requests for payment for the administration of needle EMG tests under CPT codes 95860-95864, either falsely asserting that he had administered an EMG test when in fact he did not administer one or falsely asserting that he had administered a greater number of EMG tests than he actually conducted.

I. TOTAL AMOUNT OF FRAUDULENT CLAIMS

21. During the period November 1, 1999 until March 31, 2004, CHATTHA billed, or caused his staff to submit bills, to the DOL-OWCP, the bills including, the amounts, procedures, and services listed below, which CHATTHA did not render to his patients in the manner required by established billing and medical guidelines:

SERVICE CLAIMED	AMOUNT BILLED	AMOUNT PAID	AMOUNT ALLOWABLE	AMOUNT OF ACTUAL/ INTENDED LOSS
99215	$ 104,020	$ 104,020	$ 42,805	$ 61,215
99080	$ 62,187	$ 62,187	$ 0	$ 62,187
95861	$ 12,500	$ 7,659	$ 0	$ 12,500
TOTALS	$ 178,707	$ 173,866	$ 42,805	$ 135,902

COUNTS ONE through FIFTY-ONE: (18 U.S.C. § 1347 (Health Care Fraud)

1. The allegations contained in the Introduction to this Indictment, Sections A through I, are incorporated herein as if fully set forth in each of Counts 1 through 51 as constituting the scheme to defraud and to obtain money from the DOL-OWCP, Medicare Part B Program, and California Workers' Compensation Program as identified below in Counts 1 through 51, by means of false and fraudulent pretenses, representations, and promises, in connection with the delivery and payment for health care benefits, items, and

services.

2. On or about each date set forth below in Counts 1 through 51, in the Northern District of California and elsewhere, CHATTHA, for the purpose of executing and attempting to execute the above scheme and artifice to defraud, and to obtain money by means of false and fraudulent pretenses, representations, and promises, knowingly submitted and caused to be submitted to the DOL-OWCP, Medicare Part B Program, and the California Workers' Compensation Program, the claims for payment described below in each count in connection with the delivery of and payment for health care benefits, items, and services:

COUNT	PATIENT	PAY DATE	BILLING CODE
1	Jatinder G.	2/17/00	95861
2	Jatinder G.	1/18/01	95861
3	Jatinder G.	7/18/02	95861
4	Jatinder G.	5/1/03	95861
5	Lakhbir S.	3/9/00	95861
6	Lakhbir S.	3/29/01	95861
7	Lakhbir S.	10/4/01	95861
8	Lakhbir S.	11/1/01	99215, 99080
9	Lakhbir S.	6/13/02	99215, 99080
10	Lakhbir S.	7/25/02	95861
11	Janice R.	3/13/00	95861
12	Gurdarshan S.	6/29/00	99215, 99080
13	Gurdarshan S.	9/14/00	95861
14	Gurdarshan S.	8/23/01	95861
15	Gurdarshan S.	10/4/01	95861
16	Gurdarshan S.	9/12/02	95861
17	Gurdarshan S.	6/12/03	99215, 99080
18	Gurdarshan S.	7/10/03	95861
19	Nachhtar B.	6/30/00	95861
20	Nachhtar B.	12/8/00	95861

COUNT	PATIENT	PAY DATE	BILLING CODE
21	Nachhtar B.	5/24/02	95861
22	Nachhtar B.	5/24/02	95861
23	Nachhtar B.	12/13/02	95861
24	Nachhtar B.	11/12/03	95861
25	Avtar S.	7/27/00	95861
26	Avtar S.	10/5/00	99215, 99080
27	Avtar S.	6/21/01	95861
28	Avtar S.	10/3/02	99215, 99080
29	Avtar S.	10/3/02	95861
30	Sukhdev S.	9/28/00	95861
31	Sukhdev S.	6/6/02	95861
32	Sukhdev S.	7/5/02	95861
33	Sukhdev S.	12/12/02	95861
34	Sukhdev S.	9/18/03	95861
35	Julie M.	12/15/00	95861
36	Julie M.	8/17/01	95861
37	Julie M.	1/25/02	95861
38	Gurmail B.	4/5/01	99215, 99080
39	Gurmail B.	8/22/02	99215, 99080
40	Rajwant G.	5/25/01	95861
41	Kiran M.	6/21/01	95861
42	Kiran M.	8/9/01	95861
43	Kiran M.	7/18/02	95861
44	Kiran M.	2/20/03	95861
45	Estella T.	10/18/01	99215, 99080
46	Estella T.	2/27/03	99215, 99080
47	Estella T.	3/20/03	95861
48	Balwinder M.	12/14/01	95861
49	Balwinder M.	6/7/02	95861
50	Balwinder M.	3/21/03	95861

COUNT	PATIENT	PAY DATE	BILLING CODE
51	Balwinder M.	12/1/03	95861

All in violation of 18 U.S.C. § 1347.

COUNTS 52 through 102: (18 U.S.C. § 1341 (Mail Fraud))

1. The allegations contained in the Introduction, Sections A through I, to this Indictment are realleged as if fully set forth in each of Counts 52 through 102 as forming CHATTHA's scheme to defraud in connection with the delivery of or payment for health care benefits, items, and services.

2. On or about the dates listed below in Counts 52 through 102 in the Northern District of California and elsewhere, CHATTHA, did, for the purpose of executing and attempting to execute the above scheme and artifice to defraud, knowingly cause United States Treasury checks and insurance company reimbursement checks described below in Counts 52 through 102 to be sent and delivered by the United States Postal Service, each mailing constituting a separate and distinct violation of 18 U.S.C. §1341.

COUNT	PATIENT	PAY DATE
52	Jatinder G.	2/17/00
53	Jatinder G.	1/18/01
54	Jatinder G.	7/18/02
55	Jatinder G.	5/1/03
56	Lakhbir S.	3/9/00
57	Lakhbir S.	3/29/01
58	Lakhbir S.	10/4/01
59	Lakhbir S.	11/1/01
60	Lakhbir S.	6/13/02
61	Lakhbir S.	7/25/02
62	Janice R.	3/13/00
63	Gurdarshan S.	6/29/00

COUNT	PATIENT	PAY DATE
64	Gurdarshan S.	9/14/00
65	Gurdarshan S.	8/23/01
66	Gurdarshan S.	10/4/01
67	Gurdarshan S.	9/12/02
68	Gurdarshan S.	6/12/03
69	Gurdarshan S.	7/10/03
70	Nachhtar B.	6/30/00
71	Nachhtar B.	12/8/00
72	Nachhtar B.	5/24/02
73	Nachhtar B.	5/24/02
74	Nachhtar B.	12/13/02
75	Nachhtar B.	11/12/03
76	Avtar S.	7/27/00
77	Avtar S.	10/5/00
78	Avtar S.	6/21/01
79	Avtar S.	10/3/02
80	Avtar S.	10/3/02
81	Sukhdev S.	9/28/00
82	Sukhdev S.	6/6/02
83	Sukhdev S.	7/5/02
84	Sukhdev S.	12/12/02
85	Sukhdev S.	9/18/03
86	Julie M.	12/15/00
87	Julie M.	8/17/01
88	Julie M.	1/25/02
89	Gurmail B.	4/5/01
90	Gurmail B.	8/22/02
91	Rajwant G.	5/25/01
92	Kiran M.	6/21/01
93	Kiran M.	8/9/01

COUNT	PATIENT	PAY DATE
94	Kiran M.	7/18/02
95	Kiran M.	2/20/03
96	Estella T.	10/18/01
97	Estella T.	2/27/03
98	Estella T.	3/20/03
99	Balwinder M.	12/14/01
100	Balwinder M.	6/7/02
101	Balwinder M.	3/21/03
102	Balwinder M.	12/1/03

DATED: _____

A TRUE BILL.

_____
FOREPERSON

KEVIN V. RYAN
United States Attorney

_____
JONATHAN HOWDEN
Chief, Organized Crime Drug
Enforcement Task Force

(App'd as to form: _____)
AUSA Davis